Dane County SSI MC
Quality Assurance Workgroup
Minutes 11/19/04

Present:	**Joyce Allen, Division of Disability and Elder Services (DDES) Co-Chair** **Dr. Michelle Urban, Division of Health Care Financing (DHCF) Co-Chair** **Melissa Thielman, Community Living Alliance (CLA)** **Bill Greer, Mental Health Center of Dane Co. (MHCDC)** **Mary Olen, The Management Group Inc. (TMG)** **David LeCount, Dane County** **Dr. Ron Diamond, MHCDC** **Sara Roberts, CLA** **Ruthanne Landsness, APS** **Terry Lomatsch, APS** **Sheriel, Walker, MetaStar** **Peg Algar, DHCF**
Excused:	**Wendy Kilbey Warren** **Jeff Erlanger** **Peggy Michaelis, MHCDC** **Ginny Graves, TMG** **Todd Costello, CLA** **Lesly Oxley, TMG** **Cheryl Keating, CLA**

I. Introductions

- Workgroup members introduced themselves. Ruthanne Landsness is a new member joining the group from APS. She brings ten years of experience from a variety of special managed care programs, including iCARE initiative, the Partnership program, and the Family Care Program

- Joyce Allen recommended we encourage greater consumer and advocacy involvement.

II. Goals of the SSI MC Program

- As an introduction to discussion of the QI indicators, Dr. Urban gave an overview of goals for the SSI MC Program. The goals were based in part on those of the Partnership Program and have been reviewed by the SSI-Milwaukee quality workgroup. (See attachment – SSI Dane-Goals).

- All agreed that these goals were important and appropriate. No additional goals were recommended.

III. Criteria for Selection of QI Indicators

- Dr. Urban summarized the criteria adopted by the AMA, JCAHO and NCQA for choosing performance measures. (See handout: "Desirable Attributes of Performance Measures").

    - ✓ Population Relevant – imp and of use to stakeholders.
    - ✓ Based on values/ goals of program.
    - ✓ Availability of data – some data may not be available in Meds database.
    - ✓ Ease of interpretation – simple and straightforward.
    - ✓ Reliable and valid.

Additional criteria recommended by the group:

- Cost – Keep in mind what is already being collected by HSRS (despite its shortcomings) and the Partnership program. A cost-benefit analysis could be done on each effort.
- Administrative burden.
- Avoid duplication – Could eliminate the HSRS MH module and substitute the new MH web-based functional screen. (This would be contingent on approval by Secretary Nelson).

Other Discussion Points:

- Need to examine number of months of continuous enrollment. This can be an important determinate for people with MH issues because they tend to come on and off MA frequently.

Conclusion: The criteria were discussed in some detail. The group decided to use the criteria to judge the appropriateness of each quality indicator.

IV. Discussion of Quality Indicators

Dr. Urban presented a grid with domains and potential measures for consideration. Refer to attached table for a summary of this discussion.

Physical Health

- Any ambulatory sensitive condition hospitalization was rated as an acceptable measure. These are conditions that could have been treated on an outpatient basis but for some reason the person was hospitalized.

- Diabetes care management was rated as an acceptable measure. Although the caveat that good clinical outcomes are not always achieved, a process measure could be used to assure that consumers are receiving adequate care. A long-term goal of improving clinical outcomes could also be utilized as an adjunct.

- Immunization was rejected as a measure, as it is not population relevant.

- Mammography and pap tests were accepted as measures.

Dental

- Dental preventive care reflected in the encounter data was accepted as a measure.

Mental Health

Joyce Allen provided a separate list of measures/indicators for the mental health substance abuse domains. For mental health the domains were broken out between the general population of enrollees and individuals with major mental illness (or BRC populations 1 & 2). Indicators were described as either descriptive or quality indicators. The look-back period would be one year for pre and post managed care comparisons. The group did not finish reviewing all of the indicators. A summary of the indicators reviewed includes:

General Population of Enrollees

- Any Mental Health Service (not inpatient)—Descriptive; Accept

- Any Substance Abuse Service (not inpatient/detox)—Descriptive; Accept

- Any inpatient MH Hospitalization—Quality; Accept

- Any inpatient or detox Substance Abuse Service—Quality; Accept

- Emergency Detentions for MH or SA—Quality (pre-post Managed Care); Accept

- Court Ordered/Civil Coercions for MH or SA Treatment (excluding forensic)—Quality; Accept

- Suicide Rate of Enrollees—Quality; Accept

Individuals with Major Mental Illness (or BRC 1 & 2)

- Access to Evidence-Based/best Practice Mental Health Services—Quality; Accept
- Access to Medical Services—Quality; Accept
- Access to Atypical Anti-psychotics—Quality; Accept
- Continuity of Mental Health Services Pre & Post Enrollment—Quality; Accept

Comments

- It would be helpful to have someone with an understanding of mental health and AODA issues in Dane County assist in analyzing the data.
- "Trauma Services" would need to be better defined before choosing it as a quality indicator. Gathering data on trauma services may be very difficult also, because many people may be receiving services through a private therapist.
- It was decided that the MSHP and ROSA tools will be discussed next meeting. Within the two tools are sections that may be used to measure consumer satisfaction and quality of life issues.
- MetaStar will also be invited to the next meeting.

Pharmacy

- Predictive modeling may be used to look at high cost meds, multiple med users and the mean possession ratio. The mean possession ratio works as long as there are not gaps in coverage. Unfortunately, the highest risk group will be off and on Medicaid. As Dr. Diamond mentioned earlier, this data will need to be analyzed to see if there are sub-populations (such as schizophrenics) that go on and off of Medicaid and how to address those populations needs to be considered.
- Quality indicators for pharmacy could start by focussing on problematic issues such as:
    - ✓ Prescribers having patterns of bad prescribing practices over a number of their patients.
    - ✓ Consumers having prescriptions for drugs such as benzodiazapines from more than one prescriber.
    - ✓ A consumer showing prescriptions for two different anti-psychotic medications over the FDA recommended dosage.

- The Cognitive Neuro-Science Data Initiative is a grant program that is pulling together data from the department that may also be used in our managed care initiative. Dr. Urban and Joyce Allen will investigate the initiative and report back to the group.

- Pharmacy measures for the non-mental health population need to be discussed next meeting.

IV. Wrap-up and Next Meeting Agenda

- **The next meeting will be on December 13th, in the TMG conference room (suite 320, 1 S. Pickney Street), from 9:30 to 11:30.**

- We will cover consumer satisfaction tools (ROSA, MSHP)

- The indicator grid will be modified to reflect the decisions made in today's meeting.

- Details on the Evidence-Based/Best Practice Mental Health Services will be fleshed out, specifically regarding employment and housing details.

- Pharmacy measure for the non-mental health population will be discussed.